Wisconsin Jewish Conference

MJC Milwaukee Jewish Council for Community Relations

Testimony before the Senate Committee on Health, Human Services, Insurance, and Job Creation SB 375

January 17, 2008

Milwaukee Jewish Council for Community Relations: Barbara Beckert, Assistant Director
Jewish Family Services: Judy Strauss, Vice President Clinical & Counseling Services
Wisconsin Jewish Conference: Michael Blumenfeld, Executive Director

Thank you for the opportunity to testify today on behalf of our respective agencies: the Milwaukee Jewish Council for Community Relations, which represents 28 local Jewish organizations, agencies and synagogues; Jewish Family Services, which provides comprehensive social services for Milwaukee area individuals and families; and the Wisconsin Jewish Conference, which represents 17 Jewish communities throughout Wisconsin.

Jewish tradition teaches us that providing health care is not just an obligation for the patient and the doctor but for society as well. It is for this reason that Maimonides, a revered Jewish scholar, listed health care first on his list of the ten most important communal services that a city had to offer to its residents. Our tradition recognizes that good health encompasses not only the physical dimension, but also the mental, and that the obligation to maintain mental health is an important component of the broader obligation to preserve health.

Mental illness affects one in five Americans, adults and children alike. Coverage for mental health services is very limited under most private insurance plans and government programs and far more restrictive than the coverage provided for treatment of other illnesses. These inequities in the insurance statutes prevent many individuals with mental illness and substance abuse disorders from receiving medically necessary treatment. The long-term consequences of these untreated disorders are costly, in both human and fiscal terms.

Jewish agencies including Jewish Family Services (JFS), the Jewish Home and Care Center, and Jewish Social Services of Madison play a significant role in the delivery of mental health services. Our agencies are regularly contacted by individuals and families in urgent need of mental health services who have little or no insurance coverage. The majority are employed and many have insurance, but their coverage for mental health services is extremely limited or completely lacking. There is nowhere to refer these individuals who are so desperately in need of help but lack the necessary insurance coverage and financial resources. In an attempt to provide an ethical and caring response to this human suffering, JFS is one of the only agencies in the community to provide mental health services on a sliding scale, and the demand for these services has become overwhelming. As a result, our mental health services run at a significant loss because of the large number of clients who do not have coverage or have very limited coverage, and we are struggling to continue this commitment.

We strongly support enactment of legislation to reduce financial barriers to treatment, including creating parity in the treatment of physical and mental illnesses under private health insurance plans and government programs. Wisconsin is one of only twelve states which does not have mental health parity. Now is the time to improve access to mental health services by implementing comprehensive mental

health/ substance abuse parity. Therefore, we urge you to act now by unanimously recommending SB 375 for passage before the full Senate.

According to Mental Health America, thirty-eight states now have some type of mental health parity. PriceWaterhouseCoopers, LLP, and others have found that these laws have not led to significant increases in costs or in the uninsured and often premiums have decreased as a result. Wisconsin is one of only 12 states which have not addressed this essential health care issue. Mental illness affects one in four families. Although treatment works, many people do not get the help they need because of unequal coverage for mental illness and substance abuse disorders. The current Wisconsin mandatory minimums ($7000 per year for inpatient and $2000 for outpatient) have not changed in over 20 years. Weekly visits with a mental health professional will easily use up that amount well before the end of the year. And, inpatient treatment costs over $1500 a day in Wisconsin.

Businesses that provide insurance coverage of mental illnesses have also found an unexpected benefit in reduced sick leave for physical ailments. Increased productivity and fewer sick days have resulted in a net positive for these businesses. Parity makes good economic sense. It's time for a change.

Comprehensive parity will ensure that coverage for medically necessary treatment of all mental health and substance abuse disorders is no more restrictive than the coverage for other medical conditions. Please pass SB 375 now to ensure that Wisconsin residents have improved access to this essential medical care and to help end discrimination against people experiencing mental health concerns.

Thank you for your time and consideration.

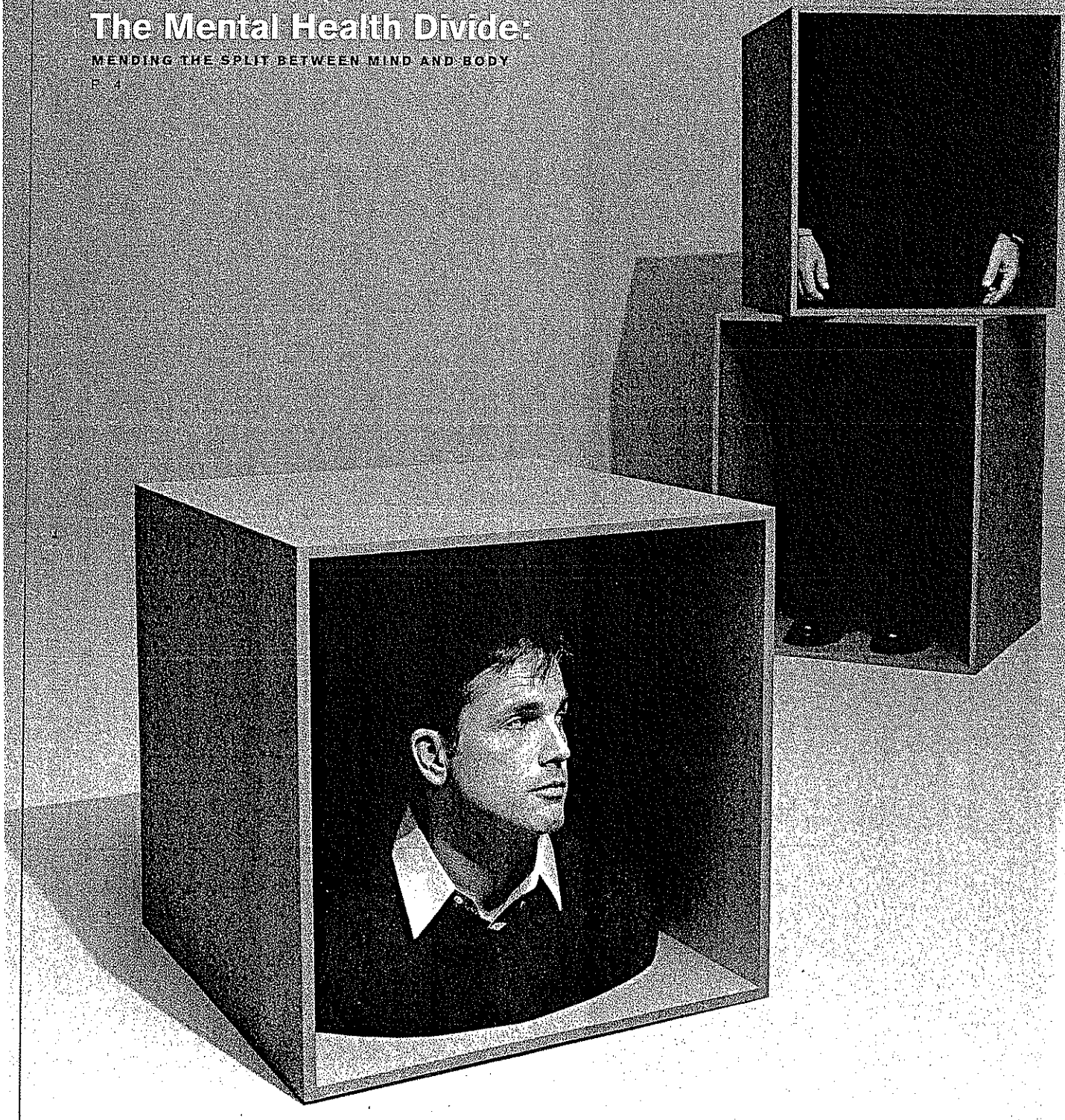
A MILLIMAN PUBLICATION
ISSUE NO. 5
AUTUMN 2007

insight

The Mental Health Divide:

MENDING THE SPLIT BETWEEN MIND AND BODY

P. 4



Letter From Milliman CEO Pat Grannan

Milliman is celebrating its 60th anniversary this year. It's humbling to look back over the years and consider the contributions from all of the professionals who got us to where we are today.

No single quality can be credited for 60 years of excellence, but if I had to pick one that is manifest in virtually everything we say and do, it would be independence. Since the firm's founding, Milliman's professionals have shared a commitment to independent thinking and objective consulting.

This is evidenced in the slate of articles in this latest issue of *Insight*. Our cover story, "The Mental Health Divide: Mending the Split Between Mind and Body," by Steve Melek, has a distinct point of view as it makes the case for rethinking the delivery of mental healthcare in the U.S. If I were to poll our consultants, I'm sure there would be some who believe another approach to mental healthcare is in order; however, I doubt that any would dispute that Steve's work on mental healthcare parity is of the highest caliber and that his story ought to be told. That is the beauty of a truly independent culture: We don't all have to agree in order to see the value of each other's perspectives.

There is a similar example of independence in the article by Ginny Boggs and Suzanne Smith, about the massive changes in 403(b) plans, a popular type of retirement plan for not-for-profit organizations. The authors raise some questions about the fees built into annuity-type products, even though our life insurance practice works extensively with clients who provide annuity products.

While I am aware of the possibility of a negative reaction from annuity providers, I would be more concerned if we allowed a conflict of interest to take root, interfering with our consultants' ability to provide the full benefit of their thinking and expertise to their clients. If we continue to provide that type of consulting to our clients, I have no doubt that, 60 years from now, Milliman will have cause for further celebration.

Pat Grannan

PATRICK GRANNAN

Milliman Chief Executive Officer

THE MENTAL HEALTH DIVIDE:

MENDING THE SPLIT BETWEEN MIND AND BODY

BY: STEVE MELEK, FSA, MAAA

"OUR PROBLEMS ARE MAN-MADE, THEREFORE THEY MAY BE SOLVED BY MAN. AND MAN CAN BE AS BIG AS HE WANTS. NO PROBLEM OF HUMAN DESTINY IS BEYOND HUMAN BEINGS."

—JOHN F. KENNEDY

Depression and other major mental and substance-related illnesses can have a paralyzing effect on an otherwise healthy person. As hope and optimism fade, so does the urge to stay healthy. Depression can compound the severity of a problem for people with chronic physical illnesses, who can cost two to three times as much to treat if they are depressed. And depression itself can lead to poor health, as it often leaves people unmotivated and causes high-risk patients to ignore prevention or necessary treatments, opening the door to chronic and acute illness.

The symbiotic relationship between behavioral health and physical health is often not recognized. Instead, the behavioral healthcare environment that has emerged in the last two decades has largely ignored the interconnectedness between mind and body. It doesn't have

to be this way. Indeed, a dramatic transformation for the healthcare industry is ahead as a handful of insurers and employers are beginning to identify the opportunities and economic incentives related to (1) providing benefits for behavioral illnesses on par with physical illnesses, and (2) integrating medical and behavioral healthcare for insured populations.

The split between mind and body in healthcare has been a problem for years, but has been convenient to ignore because, over the last two decades, costs for the care of behavioral disorders fell remarkably as managed-care business practices streamlined the behavioral healthcare industry. More recently, evidence has emerged about the adverse long-term medical effects of untreated behavioral disorders. These two dynamics now combine to suggest that parity in mental and physical health coverage—essentially, financing both on the same basis—would result in a very small added healthcare cost at worst, and quite possibly, a net reduction in total costs.

The first part of this mental healthcare transformation is embodied by the House behavioral health parity bill, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, and the Senate behavioral health parity bill, the Mental Health Parity Act of 2007. To appreciate the impact of these bills and the benefits of behavioral healthcare parity, it is useful to look back at how the current behavioral healthcare situation developed.

Behavioral Healthcare Carve-Outs: 170 Million Served

The managed-care approach to behavioral healthcare was not built in a day. In the 1980s, before managed behavioral

healthcare existed, insurance cost trends for mental health and substance-related disorders were much higher than for mainstream physical healthcare.

Inpatient treatment might have lasted weeks, if not months; recurrence rates were very high, especially with chemical dependency; and behavioral healthcare delivery was criticized as being subjective. At that time, 10 different behavioral professionals might offer 10 different remedies for depression, as compared with treatment for a common physical ailment such as appendicitis, which is almost always fairly straightforward. There was more mystique around behavioral healthcare than around medical care in general.

Early cost-reduction attempts by health insurers called for limits on covered services because insurers couldn't control how behavioral healthcare was administered. For chemical dependency, a common limit was a lifetime cap of only two stays in an addiction recovery facility—a simple way to address high recurrence rates.

With managed care, payers used two tools in the traditional medical sector: utilization management and bargaining directly with providers to lower their prices via network contracts. But the "how to" of applying these techniques to behavioral healthcare treatment was initially unclear.

Some behavioral healthcare professionals, often clinicians, saw a business opportunity. Organizations that later became known as managed behavioral healthcare organizations (MBHOs) began sprouting up to "carve out" the behavioral healthcare benefits from health plans. Typical health plans developed their own managed-care approach to physical healthcare, but rarely had the expertise to do so for behavioral healthcare. The MBHOs filled this void. These MBHOs would contract with health plans to receive a flat dollar amount per insured member per month (capitation) and manage the behavioral service risk within this budget.

This approach delegated the financial risk of insuring behavioral healthcare to the behavioral specialty companies. It became the MBHO's responsibility to build the specialty behavioral network, manage the behavioral healthcare services, pay the providers, provide customer service, and generally do everything a health plan does, but with an exclusive focus on behavioral healthcare benefits.

MBHOs grew rapidly from the mid-1980s to the late 1990s, when they served 170 million people insured by managed-care plans. These specialty behavioral healthcare organizations had financial incentives to reduce costs through utilization management and aggressive provider contracting; they even steered certain patients back into the physical healthcare system. Through effective specialty behavioral healthcare management, cost trends dropped for several years, which was the initial goal of health insurance payers. But this trend had other adverse impacts.

Adverse Effects of the Growth of MBHOs

The growth of this carve-out sector was not without its unintended consequences, not the least of which was that it truly separated the mind from the body in healthcare delivery. Because the carve-out sector is typically completely separate from the rest of the medical industry, treatment of the mind takes place in isolation from treatment of the rest of the patient. The same disconnect applies to physical health, and even problems with the brain are often treated as part of physical healthcare with little consideration of their effect on behavioral health.

This divided system misaligns patients' incentives for healthy outcomes and the overall well-being of patients suffering from behavioral disorders. Although the behavioral healthcare sector is much more effective at treating and curing behavioral disorders, insurance plans require the patient to pay more to obtain treatment within the specialty behavioral healthcare sector. And because insurance plans pay carve-outs a flat monthly fee per insured member regardless of how many patients they treat, carve-outs make more money if patients instead seek treatment within the traditional medical sector, where they typically obtain prescription medication for their disorders. Many of these medications have great promise yet turn out to be ineffectively used.

The outcomes are horrible. Only eight out of 100 patients suffering from behavioral disorders receive minimally effective treatment in the dual system that exists today. Sixty of these 100 patients receive no treatment for their disorders. And because behavioral disorders very often manifest through pain and other physical symptoms, patients often seek treatments for such physical ailments in general medical settings, without effective treatment for the root cause. In general medical settings, the percentage of patients that receive minimally effective treatment for their behavioral disorders is just 13%.[1]

The impact of behavioral illness goes beyond health insurance costs. A depressed person completes one or two fewer hours' worth of work per day than someone who is not depressed, a phenomenon known as "presenteeism." Sick days, disabilities, and on-the-job accidents also increase for employees with behavioral disorders.

Affordable Parity

Fifteen years ago, the estimated cost of mandating behavioral healthcare parity would have swallowed the profit margins of most health insurance plans. But the trend in specialty behavioral healthcare has been one of dramatically falling costs, and recent estimates of parity costs are considerably lower today than those of a dozen years ago, when the Clinton administration pushed reform efforts.

The direct effects of parity on the cost of healthcare plans come in two forms. First, cost sharing for behavioral health

1 P.S. Wang, M. Lane, M. Olfson, H.A. Pincus, K.B. Wells, R.C. Kessler, "Twelve-month Use of Mental Health Services in the U.S.: Results From the National Co-morbidity Survey Replication," *Archives of General Psychiatry*, 2005.

Status Check: Mental Health

- The number of Americans with diagnosable behavioral disorders has stayed fairly stable in recent years, at about 22%. But of 100 such patients, only 10 seek treatment in the specialty behavioral healthcare sector. Only four to five of these 10 receive minimally effective treatment that leads to recovery.[2]
- Of the remaining 90 patients, 60 receive no specific treatment for their behavioral disorders, and many are not at all aware of the underlying behavioral disorder that is contributing to their reduced health status. The remaining 30 patients seek treatment from their primary-care physicians. Of those 30, only four get minimally effective, evidence-based treatment that leads to recovery.[3]
- Of patients diagnosed with depression, some 80% initially seek treatment for pain. Depression can manifest itself through physical symptoms like headaches, stomachaches, back pain, and joint pain.
- A patient with diabetes and depression costs twice as much to treat on average as a diabetic who is not depressed. Of that extra cost, 80% is for treating the physical ailment that is exacerbated by the depression. With some chronic medical illnesses, a depressed patient can cost three times as much as a non-depressed patient.[4]
- In the primary-care sector, the typical treatment for a patient diagnosed with mental health disorders is a psychotropic drug prescription, often with very little education about what to expect from the drugs and how long before they become effective. Many antidepressants require two months of daily doses to become effective, and six months of daily doses to fully achieve remission of the mental disorder. Most come with side effects that make the patients feel worse long before they feel better. One-third of patients don't even finish the first month of their prescriptions.
- Most behavioral disorders are curable if treated properly with professional therapy, drug treatments, or a combination of both, yet only eight out of 100 patients receive minimally effective treatment in the dual system that exists today.

FIGURE 1. TYPICAL COST INEQUITY IN MENTAL HEALTHCARE

TYPE OF CARE	Surgery for appendicitis	Mental health treatment (inpatient)
DEDUCTIBLE	$250	$2,000
COPAY	For primary-care doctor: $10	For mental health professional: $25–$50
INSURANCE COVERAGE	90% of surgery costs, up to $1,000 out-of-pocket limit	70% of treatment costs, up to $5,000 out-of-pocket limit

services would be made equal to the cost-sharing provisions for physical care, which would raise insured healthcare costs. Second, the benefit limits that most plans apply to mental health conditions—like annual caps on therapy sessions or hospital stays—would be removed, also bringing the potential to raise insured healthcare costs.

The insurance industry had feared that removing these annual caps would provide a blank check for beneficiaries to over-use behavioral services. But the behavioral healthcare industry has transformed so dramatically over the last two decades that this "Chicken Little" prediction is highly unlikely.

For example, many plans have annual inpatient day limits, such as 60 days per year, on hospital stays for behavioral disorders. But admissions rarely last longer than 10 days. To break the limit, patients would have to be readmitted several times in the same year, and have relatively long inpatient stays. This may be common among pop stars or fugitives, but for the average (managed) behavioral health patient is very unlikely.

Higher insured out-of-pocket payments and policy limits have created great obstacles for people who actually need the specialty behavioral care (see Figure 1). These limits were put in place to purposely raise the cost to patients and prevent the runaway utilization of services at a time when excessive utilization was a real problem. But cases of runaway demand and high utilization are rare when these benefits are managed.

Additionally, for employers, while parity may require slightly more up-front spending on behavioral healthcare services, it could save two to three times the extra expenditures in reduced absenteeism and disability costs, lower accident rates among employees, and improve productivity in the workplace.

Policy Wrangling

Estimates of the potential industry-wide cost increases from mandated behavioral healthcare parity have fallen from 3% or 4% in the early 1990s to 0.6% or lower today, based on a recent Milliman study. The 0.6% cost impact of parity is based on a scenario that assumes plans do not increase their utilization management of behavioral benefits. If all plans increased their utilization management in response to mandated parity, costs could rise by less than 0.1%. The Congressional Budget Office agrees, recently reporting a 0.4% estimated cost impact. None of these analyses consider the effect of cost offsets from savings in other healthcare services, such as the potential for reduced visits to primary-care doctors or emergency rooms. All of these estimates are aggregates, and the impact for particular programs can vary.

As a result of parity, cost increases could be as high as 2% to 3% for some plans, such as those without managed care that have very little existing behavioral healthcare coverage. But these plans make up less than 5% of all group plans.

Two competing bills in Congress that would establish parity, S.558 in the Senate and H.R.1424 in the House, have received objections on the basis that attempts to achieve parity would result in runaway costs. But according to the Milliman analysis, the House's more extensive Wellstone Act would raise individual premiums by between $0.03 and $2.40 per insured person per month.

Today, as treatment costs have continued to fall dramatically in the carve-out sector, the parity argument is no longer over high costs or whether it is the right thing to do, but over which parity bill in Congress is better. The House bill is a bit more comprehensive than the Senate bill, but projected costs are comparable. To an outsider, the debate has apparently shifted from costs to politics.

Parity would help improve access, but what's really needed is an integrated healthcare delivery system, one where medical and behavioral healthcare providers deliver coordinated healthcare in a collaborative fashion. Evidence is beginning to suggest that the long-term costs of not treating behavioral health problems, or solely treating them in isolation from other medical issues, may result in total healthcare costs that are much higher than necessary. In medical settings, patients may seek repeated and ineffective care from medical or surgical physicians, rather than more effective specialized care from specialty behavioral professionals.

Twenty-five percent to 40% of patients with a chronic, costly physical condition also have a diagnosable psychological disorder—that's a rate 50% to 100% higher than in the general population, and these are often severe cases.[5] What's more, a disorder like depression can exacerbate a physical illness and lead to increased medical costs. Integrating behavioral healthcare with the rest of the mainstream healthcare system may help catch these double-whammy situations before they do lasting damage to patients and drive up overall healthcare costs. This is the second part of the transformation beginning to occur in the delivery of behavioral healthcare.

Changing the Status Quo

Three core elements of the behavioral healthcare system must each be altered in order to achieve a truly integrated approach:

- Benefit financing, which parity goes a long way toward improving
- Integrated case and disease management that addresses patients with physical and behavioral disorders
- Day-to-day recognition and responsibility for both physical and behavioral outcomes by all treating clinicians

Many healthcare professionals now argue that ineffective or nonexistent behavioral treatment negatively affects the healthcare system as a whole—and the employers and workers who support and depend on it. This hypothesis is gaining support, although the longitudinal studies to provide conclusive evidence of this are still in the early stages.

Fully integrating the behavioral health system with the rest of the mainstream healthcare system could take a generation to complete, just as it took a generation for the MBHOs to prove that specialty behavioral healthcare could be provided at a reasonable cost. But for the time being, the 92 patients out of 100 diagnosable ones who aren't getting minimally effective treatment are adding costs to health plans and the employers who sponsor them.[6,7,8] M

STEPHEN P. MELEK *is a principal and consulting actuary with the Denver office of Milliman. He has extensive experience in the behavioral healthcare specialty field and has focused on parity issues (including recent Congressional testimony) and cost analyses, mental health utilization and costs in primary-care and emergent settings, psychotropic drug treatment patterns and application of quality algorithms, and strategic behavioral healthcare system design.*

2 Narrow et al., op. cit.
3 Wang et al., op. cit.
4 Milliman proprietary research.
5 W. Katon, M. Von Korff, E. Lin, P. Lipscomb, J. Russo, E. Wagner, E. Polk, "Distressed High Users of Medical Care: DSM III-R Diagnoses and Treatment Needs," *General Hospital Psychiatry,* 1990.
6 R.C. Kessler, O. Demler, R.G. Frank, et al., "Prevalence and Treatment of Mental Disorders, 1990 to 2003," *New England Journal of Medicine,* 2005.
7 W.E. Narrow, D.S. Rae, L.N. Robins, D.A. Regier, "Revised Prevalence Estimates of Mental Disorders in the United States: Using a Clinical Significance Criterion to Reconcile Two Survey Estimates," *Archives of General Psychiatry,* February 2002.
8 P.S. Wang, O. Demler, R.C. Kessler, "Adequacy of Treatment for Serious Mental Illness in the United States," *American Journal of Public Health,* 2002.

NIAAA National Institute on Alcohol Abuse and Alcoholism

Screening and Brief Intervention: Reducing the Burden of Harmful Alcohol Use on Public Health

T.-K. Li, M.D.
Director
National Institute on Alcohol Abuse and Alcoholism

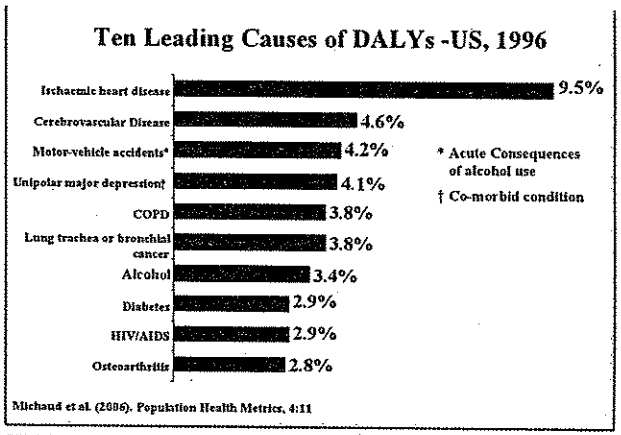
Third National Leadership Conference on Medical Education in Substance Abuse
Washington, DC
January 16, 2008

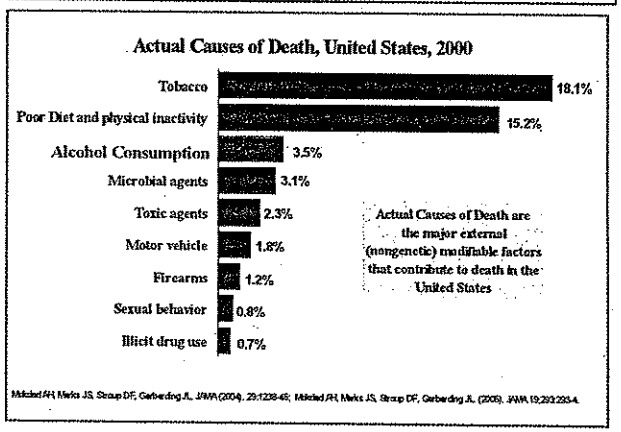
Alcohol Consumption is a Leading Risk Factor for Disease Burden in the U.S.

In the United States:

- **18 million Americans (8.5% of the population age 18 and older) suffer from alcohol use disorder, including alcoholism**
- **Over 4 million of our youth (18% of the population ages 12-17) report drinking monthly with more than half engaging in high-risk drinking patterns**
- **Alcohol problems cost U.S. society an estimated $185 billion annually**
- **Alcohol consumption is among the top 10 leading causes of DALY's* and actual causes death (~85,000 annually)**

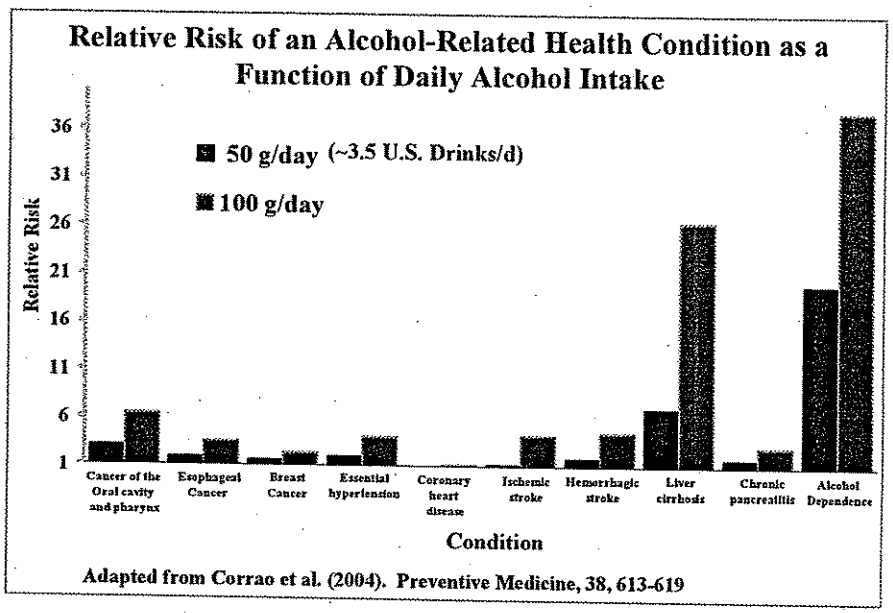
*Disability-adjusted life years (years of potential life lost due to death plus years of health life lost to disability)





Relative Risk (RR) of Chronic Consequences and Daily Alcohol Intake

- **Chronic excessive drinking leads to increased relative risk (RR) by at least 50% for all-cause mortality between 50-100g ethanol/day**
- **Variations in RR by gender, age etc.**



Adapted from Corrao et al. (2004). Preventive Medicine, 38, 613-619

Gmel et al. (2003). Eur J Epidem. 18(7) :631-42

DAVE HANSEN

SB 375—1.17.08 Testimony

Thank you, Chairman Erpenbach and committee members, for holding a public hearing today on Senate Bill 375. The weather could have been more cooperative, but we're used to that around here.

Senate Bill 375 is the latest in a long line of mental health insurance proposals that have been brought before the Senate. As many of you know, a very similar bill passed the state Senate in 2001. Since that time, unfortunately, it has never received an up or down vote in the state Senate or Assembly. We're hoping to change that this year, and I'm cautiously optimistic about our chances.

Support for the proposal has never been stronger. The coalition in support of the bill is broad and deep. And the data supportive of the cause has never been more persuasive.

Subsequent speakers will address many of these issues. They will touch on the affordability of the requirement, how business competitiveness can be positively impacted by the legislation and how worker productivity can be improved when mental health care is accessible. These facts and figures are important to keep in mind when opponents raise concerns with the legislation's impact on the business climate, but I will leave these points to the experts.

I want to just briefly explain my position on this legislation, why I am proud to author the bill and why this bill is so important from a moral and ethical perspective.

Earlier this year, I had the pleasure of attending my son-in-law's graduation from the College of Podiatric Medicine and Surgery at Des Moines University. The commencement address was delivered by former Arkansas Governor Mike Huckabee, a Republican presidential candidate and the winner of the Iowa caucuses. I was prepared for a run-of-the-mill partisan stump speech, but instead was treated to something very different by a preacher-politician who knows a thing or two about public speaking.

That day, Mr. Huckabee spoke of a young soldier who returned from Iraq with lasting psychological and emotional scars. The soldier recognized that he was in trouble and tried to get help at the local VA, but he was told to come back another day. Tragically, this young man didn't have another day. He went home and took his own life.

Huckabee passionately delivered this story, and used it as an opportunity to call for better mental health treatment for our returning soldiers who have suffered through the horrors of the Iraq War.

I wholeheartedly agree with his call, and have voted to increase funding for the state's Veterans Assistance Program, but I also recognize the problem extends far beyond the brave veterans who battle mental illness. People across this state and nation, people who have never seen a battlefield are dealing with mental illnesses that are just as real and debilitating as those faced by our men and women in uniform.

In fact, according to the Wisconsin Department of Health and Family Services, about 629 suicide deaths occur in Wisconsin, and an average of 4,944 suicide related hospitalizations take place each

year. Many of these deaths are highly preventable and could be prevented if all sufferers of mental illness had access to the prevention services they deserve.

To put it simply, current laws that allow for the inequitable treatment of mental health and substance abuse disorders are nothing more than legalized discrimination. Mental illnesses are medical problems—not character flaws—and should be treated as such.

The time has come to stand up to powerful special interests that stand in the way of progress at every turn. I plan to continue just that, and I hope that Assembly leadership will finally join me in this effort.

I'll now close with the words of one of my favorite public servants, the late Sen. Paul Wellstone, a terrific statesman and the man after whom federal mental health parity legislation is now named. He said, "Politics isn't about big money or power games; it's about the improvement of people's lives."

I hope you'll all join me in working to create this kind of politics—the kind of politics of which we can all be proud—by working to improve the lives of Wisconsinites who continue to struggle with the stigma of mental illness.

Thank you.

Mental Health America of Wisconsin

Testimony to the Senate Health and Human Services Committee
SB 375
Shel Gross; Director of Public Policy
Mental Health America of Wisconsin
(formerly the Mental Health Association)

Over the past four years our organization has done a lot of work at the interface between mental health care and primary and acute care. During this time we have come to an appreciation of the impact that mental disorders have on the ability to treat common and prevalent health conditions which employers routinely cover in their health insurance. While others today will address the direct impact of mental illnesses on employer costs and productivity I would like to bring your attention to the indirect, but significant impact that mental health issues have when they impact other disorders. The following information is from the Center for Disease Control and Prevention[i].

Asthma

- People with frequent asthma attacks are more than 3 times more likely to have psychopathology than people with less frequent attacks.
- This psychopathology is associated with more visits to primary care providers, emergency departments and hospitals.
- Cognitive behavior therapy has yielded significant decreases in asthma symptoms.

Arthritis

- Depression is associated with increased activity restriction, increased disability and increased symptoms among individuals with arthritis.
- Combinations of psychotherapy and medication fostered improvement in depressed mood and subsequent improvement in functional status.

Heart Disease

- The risk for developing heart disease in individuals with depression is 1.6 times greater than among non-depressed patients, which is more risk than that conferred by passive smoking.
- Persons with depression are more than four times as likely to have a heart attack than individuals with no history of depression, and are more likely to have medical comorbidities and are at greater risk of mortality.

(over)

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Diabetes

- Depression is twice as prevalent among persons with diabetes than in the general population and is associated with increased diabetic-related complications.
- Total health expenditures for persons with depression and diabetes are 4.5 times higher than for those without depression.
- Treatment through cognitive behavior therapy and medication reduces depression and improves glylcemic control.

What all this amounts to is that the failure to address mental disorders can lead to increased medical costs for the treatment of other disorders, which are likely to increase health care premiums, and also lead to functional deficits that will impair an employee's productivity.

Health insurance is a business investment. When employees (and their family members) are healthy they can work at their maximum level of productivity. Employers undermine this investment when they fail to provide adequate mental health treatment as part of their health care plan.

I urge you to vote in favor of SB375

Thank you.

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[i] Chapman, DP, Perry, GS, Strine,TW. The vital link between chronic disease and depressive disorders. Prev. Chronic Dis [serial online] 2005 Jan. Available from URL: http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm

WISCONSIN CATHOLIC CONFERENCE

TO: State Senator Jon Erpenbach, Chair
Members, Senate Committee on Health, Human Services, Insurance, and Job Creation

FROM: John Hrobscher, Executive Director

DATE: January 17, 2008

RE: Senate Bill 375, Mental Health and Substance Abuse Parity

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On behalf of the Wisconsin Catholic Conference, the public policy voice of Wisconsin's Roman Catholic bishops, I wish to express our support for Senate Bill 375. This bill would enhance health insurance coverage requirements in Wisconsin for mental illness and substance abuse, ensuring that those who suffer from these conditions receive the same care and treatment as those who have physical health issues.

SB 375 proposes a sensible policy that reflects medical science's current understanding of the intricate link between mental and physical health. Mental health conditions and substance abuse can be as debilitating as any physical injury, and yet, those who suffer such affliction have traditionally not received the same opportunity to access treatment.

This bill corrects that inequity by removing the state's minimum coverage amounts for group health insurance for these conditions and instead requiring that group insurers provide the same coverage for the treatment of mental health and substance abuse conditions as they would for any physical ailment. The bill also ensures that certain individual plans that opt to provide mental health and substance abuse coverage do so in a manner that is equivalent to the coverage provided for the treatment of physical conditions.

The human person is more than a physical body. Our human nature blends the physical with the intellectual and spiritual. The latter two may be harder to quantify but are no less deserving of our attention. Further, each of us possesses an innate dignity with which, in the words of the Founders, we are endowed by the Creator. This human dignity is present even when one is physically, mentally, or emotionally afflicted.

Since all of us suffer when illness robs our neighbor of his or her ability to contribute to the community, we have a shared responsibility to support those who find themselves in a condition of serious mental illness. The mental health needs of our neighbors, no less than their physical well-being are a proper concern of public policy. It is, therefore, appropriate for laws to foster greater equity in how we deal with mental and physical illness.

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Proper treatment of mental health and substance abuse not only serves the human dignity of the individual afflicted with a condition or addiction; it also serves to enhance the safety and security of our communities. Indeed, one of the issues that continually surfaced as the bishops studied the issue of crime and the criminal justice system in this state was the percentage of prisoners with mental illness and addictions. Mental illness and substance abuse issues also clearly intertwine with other social concerns such as poverty.

Establishing parity coverage for those who suffer from substance abuse, mental health issues, and physical illness, recognizes the fullness of the human person and fosters a consistent life ethic. These are worthy policy objectives.

We respectfully request your support for SB 375 and thank you for your consideration.

1. AARP Wisconsin
2. AFL-CIO
3. AFSCME Council #24
4. American Federation of Teachers (AFT) - Wisconsin
5. American Heart Association
6. American Society of Addictive Medicine - Wisconsin
7. Anorexia Nervosa & Associated Disorders
8. Archdiocese of Milwaukee, Social Concerns Office
9. Associated Counseling & Recovery Center LLC - Fond du Lac
10. Association of School Boards
11. Autism Society of Wisconsin
12. Bulimia Education & Support Training
13. Catholic Health Association of Wisconsin (CHA-W)
14. Citizen Action of Wisconsin
15. Coalition for Fairness in Mental Health and Substance Abuse Insurance
16. Coalition for Wisconsin Health
17. College of Nursing - Marquette University
18. Consumers of Positive Effect
19. Cornucopia
20. Cyber Phoenix Project
21. Dane County Chemical Dependency Consortium
22. Dennis Hill Harm Reduction Center
23. Depression and Bipolar Support Alliance
24. Disability Rights of Wisconsin
25. Earth Angels Training Team
26. Elkhart Psychological Services
27. Employee Assistance Professionals Association - South Central Wisconsin
28. Employment Resources, Inc.
29. Encompass-Effective Mental Health Services
30. Epilepsy Foundation of South Central Wisconsin
31. Epilepsy Foundation of Southern Wisconsin
32. Epilepsy Foundation of Western Wisconsin
33. Family Planning Health Services, Inc.
34. First Congregational Church Forum - Madison
35. Friendships Unlimited
36. Genesis 1990
37. Grand Avenue Club
38. Grassroots Empowerment Project

39. Gundersen Lutheran
40. Hispanic Chamber of Commerce - Wisconsin
41. Inacom Information Systems
42. Independent Care Health Plan (iCARE)
43. InHealth WI
44. Interfaith Conference of Greater Milwaukee
45. International Association of Psychological Rehab Services-Wisconsin
46. Jewish Family Services - Milwaukee
47. Koller Behavioral Health Services
48. Lutheran Office for Public Policy in Wisconsin
49. Managed Health Services (MHS)
50. Matt Talbot Recovery Center
51. Medical College of Wisconsin
52. Mental Health America of Wisconsin
53. Mental Health Center of Dane County, Inc.
54. Mental Health Coalition of the Greater La Crosse Area
55. Mental Health Consumer Network
56. Milwaukee Area Health Education Center (AHEC)
57. Milwaukee Coalition on Mental Illness
58. Milwaukee Jewish Council for Community Relations (MJCCR)
59. Milwaukee Mental Health Task Force
60. Ministry Health Care – Saint Clare's Hospital
61. NARAL Pro-Choice Wisconsin
62. National Alliance on Mental Illness (NAMI) Dane County
63. National Alliance on Mental Illness (NAMI) Wisconsin
64. National Association of Health Education Centers - NAHEC
65. National Association of Social Workers (NASW) - Wisconsin Chapter
66. New Horizons North - Community Support
67. North Country Independent Living
68. Northeastern Wisconsin Area Health Education Center, Inc.
69. Northern Wisconsin Area Health Education Center (NAHEC)
70. Northwest Counseling Services
71. Nova Counseling Services - Oshkosh
72. Pathways to Independence, Waisman Center
73. Perinatal Foundation
74. Planned Parenthood of Wisconsin
75. Racine Friendship Clubhouse
76. Reach Counseling Services - Menasha
77. Regional Employee Assistance Services
78. Representative Alvin Ott
79. Representative Chuck Benedict
80. Representative Donna Seidel
81. Representative Frank Boyle
82. Representative Gary Sherman
83. Representative James Soletski
84. Representative Jason Fields

85. Representative Jeff Smith
86. Representative Mark Pocan
87. Representative Mike Sheridan
88. Representative Robert Turner
89. Representative Sheryl Albers
90. Representative Sondy Pope-Roberts
91. Representative Therese Berceau
92. Rogers Behavioral Health System, Inc.
93. Rogers Memorial Hospital
94. Rosebud & Friends
95. Senator Dave Hansen
96. Senator Jon Erpenbach
97. Senator Judith Robson
98. Senator Kathleen Vinehout
99. Senator Mark Miller
100. Senator Risser
101. Senator Robert Wirch
102. Senator Sheila Harsdorf
103. Senator Tim Carpenter
104. Shorehaven Behavioral Health, Inc.
105. Sixteenth Street Community Health Center
106. Society's Assets
107. SoSiab Care, Inc.
108. Southern Services Center for Independent Living
109. Southwest Wisconsin AHEC
110. Stowell Associates SelectStaff, Inc.
111. Substance Abuse Services Network
112. Survival Coalition of Wisconsin Disability Organizations
113. SWCAP Reproductive Health Care Center
114. Systemic Perspectives
115. Tellurian UCAN, Inc.
116. The Consumer Satisfaction Team
117. The Dane County Mental Health Consortium
118. The Gathering Place
119. The Open Gate
120. The Partners Advocacy
121. The United Community Center
122. The Wisconsin Coalition Against Sexual Assault, Inc. (WCASA)
123. The Wisconsin Pathways to Independence
124. The Wisconsin Prevention Network
125. The Wisconsin Primary Health Care Association (WPHCA)
126. Transitional Living Services
127. Tri-County Council on Domestic Violence & Sexual Assault
128. United Cerebral Palsy of Wisconsin
129. United Way Fox Cities
130. United Way of Greater Milwaukee

131. United Way of Wisconsin
132. University of Wisconsin -Baraboo/Sauk County
133. University of Wisconsin School of Medicine and Public Health
134. University of Wisconsin Stout
135. University of Wisconsin System
136. UW Health
137. UW La Crosse
138. UW Medical School-WI AHEC System, Inc.
139. UW Richland
140. UW Rock County
141. UW Vets for Vets
142. Voices of Hope Consumer Group
143. Waukesha Memorial Hospital -Behavioral Medicine Center
144. Wisconsin Catholic Conference
145. Wisconsin AHEC, Program Office
146. Wisconsin Alcohol and Drug Treatment Providers Association
147. Wisconsin Alcohol, Drug and Disability Association
148. Wisconsin Alliance for Women's Health (WAWH)
149. Wisconsin Association for Perinatal Care (WAPC)
150. Wisconsin Association of Family & Children's Agencies
151. Wisconsin Association of Local Health Departments and Boards (WALHDAB)
152. Wisconsin Association of Local Health Departments and Boards (WALHDAB)
153. Wisconsin Association of Marriage and Family Therapy
154. Wisconsin Association on Alcohol and Other Drug Abuse
155. Wisconsin Chapter, American Academy of Pediatrics (WIAPP)
156. Wisconsin Coalition Against Domestic Violence (WCADV)
157. Wisconsin Coalition of Independent Living Centers
158. Wisconsin Community Action Program Association (WISCAP)
159. Wisconsin Community Services, Inc.
160. Wisconsin Correctional Service
161. Wisconsin Council on Mental Health
162. Wisconsin Department of Veterans Affairs
163. Wisconsin Family Planning and Reproductive Health Association (WFPRHA)
164. Wisconsin Family Ties
165. Wisconsin Federation of Nurses & Health Professionals (WFNHP)
166. Wisconsin Independent Businesses, Inc. (WIB)
167. Wisconsin Interfaith IMPACT
168. Wisconsin Jewish Conference
169. Wisconsin Medical Society
170. Wisconsin Mental Health Association
171. Wisconsin Nurses Association (WNA)
172. Wisconsin Office of Rural Health
173. Wisconsin Psychiatric Association

174. Wisconsin Psychological Association
175. Wisconsin Public Health Association (WPHA)
176. Wisconsin School Psychologists Association, Inc.
177. Wisconsin United for Mental Health (WUMH)
178. Wisconsin Women's Health Foundation, Inc. (WWHF)
179. Write Resources, LLC